Banner Health

NEW PATIENT MEDICAL HISTORY
SPINE SURGERY

Patient Name: _____ **Date of Birth:** _____

Gender Identity (Optional) _____

Please provide as much detail as you are able so that we can give you the safest and best care possible.

Preferred Pharmacy (name and location): _____

Primary Care Provider

Name: _____ Phone #: _____

Address: _____ Fax #: _____

Briefly describe the onset of your current pain and events preceding your pain. When and how did it begin?

_____

_____

List all providers who have treated you for this issue: _____

_____

_____

Did you bring X-Rays / EMG / CT / MRI today? ❑ Yes ❑ No

Is this a work related injury? ❑ Yes ❑ No If yes, will you be using workman's comp benefits? ❑ Yes ❑ No

ALLERGIES

List any allergies and intolerances to **medications, food or the environment.** ❑ No Known Allergies

Allergy:	**Reaction:**

MEDICATIONS

❑ Not taking any medications

List any medications, vitamins, supplements, and over the counter medications you are taking, with dose and how often.

Medication Name:	**Dose:**	**How often?**

Are you on aspirin or a blood thinner, such as Warfarin / Xeralto / Plavix / Coumadin / Pradaxa?

❑ Yes ❑ No If yes, medication with dose and frequency: _____

If no, has a physician advised you not to take aspirin? ❑ Yes ❑ No

DO NOT RETAIN AS PART OF THE PERMANENT MEDICAL RECORD

9999-0173
(02/2021)

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MEDICAL HISTORY

List all medical conditions you are being treated for (high blood pressure, etc.)

1.	**4.**
2.	**5.**
3.	**6.**

Have you had any recent hospitalizations or ER visits (provide dates and reason below)?

❑ No prior hospitalizations/ER visits

Date	

SPINE SURGICAL HISTORY

List all prior surgeries especially spinal and the date ❑ No prior surgeries *Outcome (Poor, good or excellent)

Date	**Type of Surgery**	***Rate the outcome**	**Date**	**Type of Surgery**	***Rate the outcome**

FAMILY HISTORY

List health conditions for each family member.

	Alive	Deceased	Age of Death	Health Condition(s)
Father				
Mother				
Brothers				
Sisters				
Daughter				
Son				

SOCIAL HISTORY

Occupation _____ Employer _____

Tobacco/smoking status:	❑ Never				
	❑ Current	Type	Amount	Duration	
	❑ Former	Type	Amount	Duration	
Do you use alcohol?	❑ No	❑ Yes	Type	Amount	Frequency
Do you use recreational drugs?	❑ No	❑ Yes	Type	Amount	Frequency
Do you use Caffeine?	❑ No	❑ Yes	Type	Amount	Frequency

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PAIN ASSESSMENT

When did symptoms begin: _____/_____/ _____

Which is your dominate hand? Right / Left

Location of pain/symptoms:
❑ Brain/head ❑ Face ❑ Neck ❑ Arm(s)
❑ Upper back ❑ Lower back ❑ Hip ❑ Leg(s)

Severity of Pain (0=min, 10=max): _____

Pain Frequency: (mark all that apply)
❑ Rare ❑ Occasional ❑ Constant
❑ Stairs only ❑ Stairs and walking

Status:
❑ Worse ❑ Stable ❑ Improving ❑ Resolved

Radiation of pain:
❑ No ❑ Yes, radiates to: _____

❑ Aching ❑ Burning ❑ Dull
❑ Piercing ❑ Sharp ❑ Throbbing
Other: _____

Injury/Trauma? ❑ No ❑ Yes
If Yes, when/where? (work, school, vacation, automobile, other): _____

Aggravated by: (mark all that apply)
❑ Bending ❑ Lifting ❑ Sitting
❑ Climbing stairs ❑ Movement ❑ Standing
❑ Descending stairs ❑ Pushing ❑ Walking

❑ Nothing
Other:_____

Prior treatment: (mark all that apply)
❑ Brace/splint ❑ Ice ❑ Mobility
❑ Elevation ❑ Injection ❑ Stretching
❑ Exercise ❑ Massage ❑ Physical Therapy
❑ Heat ❑ Rest ❑ Nothing
❑ OTC/prescription meds: _____
Other: _____

Did any of the prior treatments above give relief?
If so, please list: _____

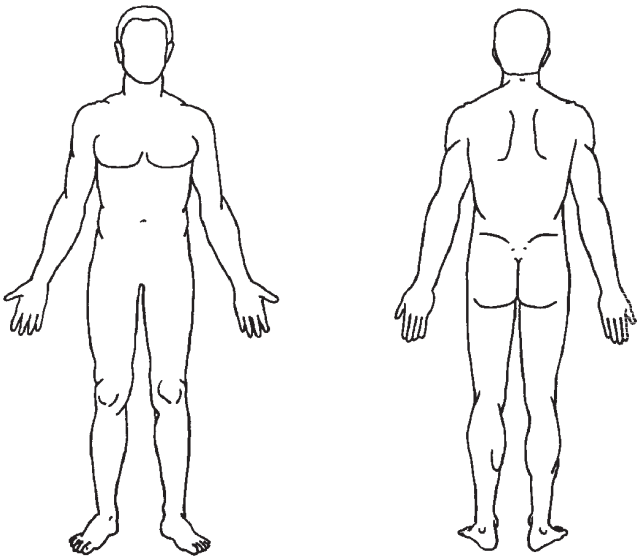
Associated symptoms: (mark all that apply)
❑ Bruising ❑ Limping
❑ Spasms ❑ Pain after inactivity
❑ "Crunching" ❑ Locking
❑ Swelling ❑ Stiffness
❑ Decreased mobility ❑ Wake at night
❑ Tingling in arms ❑ Tingling in legs
❑ Pain at night ❑ Difficulty going to sleep
❑ Joint feels unstable ❑ Numbness
❑ Weakness ❑ Joint tenderness
❑ "Popping"
Other: _____

Functional Abilities: Can you…

Get in/out of car	❑ Yes	❑ No	❑ With difficulty
Kneel	❑ Yes	❑ No	❑ With difficulty
Put on sock/shoes	❑ Yes	❑ No	❑ With difficulty
Go down stairs	❑ Yes	❑ No	❑ With a rail
Go up stairs	❑ Yes	❑ No	❑ With a rail
Sit in chair	❑ 1 hr.	❑ 30 min.	❑ Difficult
Walking distance:	❑ indoors	❑ Less than 5 blocks	
	❑ 5-10 blocks	❑ More than 10 blocks	

Do you require a…
❑ Cane ❑ Crutches
❑ Walker ❑ Wheelchair ❑ None

Indicate on the drawing below where you have symptoms.



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NUMBNESS/TINGLING

This section pertains to numbness/tingling **only.** Questions about pain are on the previous page.

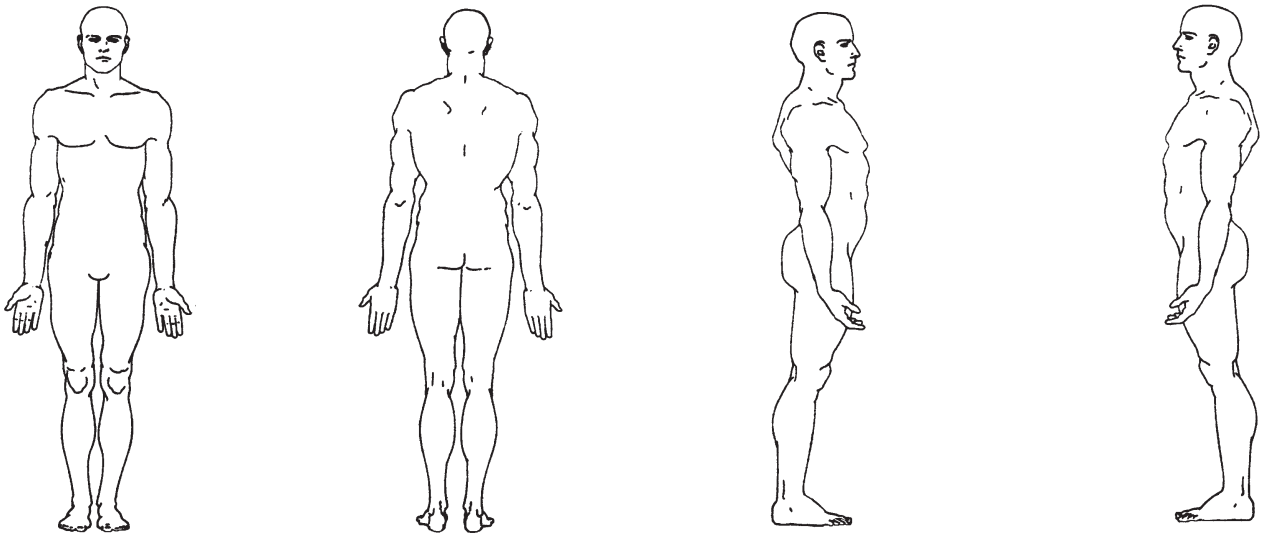
Do you feel numbness or tingling?

❑ No

❑ Yes

If Yes, please mark on the figure below to show where you feel **numbness (loss of feeling) or tingling (pins and needles).**

FRONT BACK RIGHT LEFT



My numbness and tingling is made worse while .....

❑ Walking ❑ Running ❑ Standing ❑ Sitting ❑ Bending ❑ Lifting ❑ Driving

❑ Heat ❑ Ice ❑ Exercising ❑ Frequent change of position

❑ Sports (list) _____ ❑ Other (describe) _____

❑ Nothing makes my numbness/tingling worse

My numbness and tingling is made better while .....

❑ Walking ❑ Running ❑ Standing ❑ Sitting ❑ Bending ❑ Lifting ❑ Driving

❑ Heat ❑ Ice ❑ Exercising ❑ Frequent change of position

❑ Sports (list) _____ ❑ Other (describe) _____

❑ Nothing makes my numbness/tingling better

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